

## On Cutting Costs in Health Care

IT IS NO NEWS that efforts to cut or even contain rising costs of health care have so far been singularly unsuccessful. Further, during the past year or so there appears to have been an unprecedented nationwide increase in the usage of health care services, a usage so great that it begins to threaten the financial solvency of health care programs of all kinds and even of the health insurance industry itself, with all that this implies. It is becoming imperative that something be done.

So far the approaches have been unbelievably simplistic and naive. Doctors have been blamed for increased utilization because after all it is they who order the services. Increased costs are also blamed upon the doctors who increased their fees, thus supposedly accounting for the increased costs, or upon alleged waste or inefficiency in the delivery of services. This has been great sport, but it has accomplished little because these are not the causes of the problem.

The true causes can be seen by simply looking at them. For one thing the dollar just isn't worth as much, and this alone makes the dollar costs in health care rise. But there are other causes. These may be grouped under progress in medical science, oversell of what medical science can do, and changing public attitudes. For the first, there is no doubt that much more can be done than before, that many more services can be useful for many more people, and that greater sophistication in health care generally results in greater costs. For the second, there is reason to believe that health maintenance has been greatly oversold in terms of what it can accomplish; certainly there is evidence that we are developing a drug-

oriented if not a drug-dependent culture and counter culture, and surely the decisions and awards of juries in malpractice action suggest that many persons are convinced that modern medical science is capable of more than it often is. And third, changing public attitudes have perhaps had the most important influence of all. High quality health care for all has been determined to be a right, and it is proving unexpectedly costly to make good on this commitment. Charity is giving way to dignity and equality not only for patients but for workers in the health care field, and this is another major factor in the rising costs. And most recently there has been an enormous and disproportionate increase in the number of hysterectomies, vasectomies and abortions which can be readily interpreted as reflecting the new social attitudes toward population control and unwanted children. In a real sense many of these are social services, yet their costs are ascribed to health care, and add significantly to the total.

Since the demands for health services are evidently unlimited and since what can be paid out for them is just as evidently limited, some action must be taken to bring what must be done into the range within which the people and the nation are willing and can afford to pay. Cutting physicians' fees or the allowable patient care services has so far been the main approach, but it has accomplished little and in the long run is likely to accomplish even less. Indeed it is about as simplistic and naive as is the accusation that all the trouble is due to the cupidity and inefficiency of physicians.

What, then, might be the approach? To start off, it might be acknowledged that adequate nutrition, satisfactory housing, sufficient economic maintenance and a certain level of education are more essential to achieving and maintaining a state of health than are any amount of federal, state or private health services. These costs should be separated out from the costs of health maintenance and health care, whether the patient is sick or well. True, there should be more em-

phasis on efficiency in health care delivery, but this emphasis should shift sharply from a frustrating and futile attempt simply to provide more of the same services to more people at the same or less cost. Rather it should be on reducing the number of unnecessary and unproductive services. Quite simply, those which are not worth their cost will have to be eliminated. This will require a challenge to many widely accepted but unproven assumptions with respect to the value of various products and services, and the circumstances of their use. Much more could be accomplished if the demand for unneeded services could be lessened without sacrifice of either the quantity or quality of what is truly necessary. For example, unnecessary services in enormous number are performed each day to relieve fears of heart disease, stroke or cancer—fears which we must admit have been publicly engendered by well-intentioned efforts to reduce disability and death from these conditions. And research should also be mentioned. For any disease the costs of care increase as progress is made against the disease until a major breakthrough occurs, following which the costs are sharply reduced. Tuberculosis, poliomyelitis and phenylketonuria may be cited as examples. However, the national policy of the moment is to curtail research and divert much of the available funds to patient care. Many questions could be asked as to whether this policy is wise or unwise in terms of present and future health care costs.

In conclusion it appears that the present problems are those of success—success in medical research, success in selling the public on the accomplishments of this research and the value of the health services which can now be made available, and success in moving toward the national goal of more health services for more people. It also appears that the present approach to cutting or containing costs in health care is not likely to accomplish much, and that little progress will be made until some widely accepted assumptions and attitudes with respect to the need for services are critically examined, the demand for unneeded services is substantially reduced, and much more attention is paid to the cost effectiveness of the services which are offered, with a substantial number of those which are not worth their cost being eliminated. The search for shortcuts and easy answers is likely to be both frustrating and in vain.

## Phenylketonuria, the Inborn Errors of Metabolism, and Clinical Research—1971

On looking through my reprint collection in preparation for writing this editorial, it quickly became apparent that the file on phenylketonuria is one of the thickest for any single disease. Considering the relative rarity of the disorder (with an incidence of about 1 in 20,000 births) the recent vintage of the articles in the file, and the fact that my interest in phenylketonuria is really no greater than in any of a large number of genetic disorders, why would the folder be so thick? Why should so many research papers, review articles, editorials, and letters to the editor have appeared and continue to appear, so that even a reader with only a casual interest in the subject is inundated by them? In part the reason is historical. Although it was not the earliest inborn error described—Garrod's description of albinism, alkaptonuria, cystinuria and pentosuria antedate it by 30 years—it was the first metabolic cause of mental retardation to be genetically and biochemically defined, one of the first verified by enzyme studies, and, perhaps most importantly, one of the first for which a specific mode of therapy was developed. As a result, phenylketonuria became the prototype of the inherited enzyme defects and the subject of the considerable research activity which is represented in many publications. But, these "firsts" do not explain all of the interest in the disease, especially that in the last few years, and much of the explanation must be sought in the complexities of the disorder itself.

In the present issue of *CALIFORNIA MEDICINE*, Blaskovics and Nelson ably review many of the facets of phenylketonuria which are under active study and discussion. In broad terms these include the relationship of the mental retardation to the metabolic defect, the heterogeneity of conditions producing hyperphenylalaninemia, the effects of maternal phenylketonuria on fetal brain